LONG ISLAND SPINE SPECIALISTS, P.C.
Committed to Excellence, Committed to You
631-462-2225 www.lispine.com

NEW PATIENT INFORMATION FORM

Committed to Excellence. Committed to You.
Please print all Information. All blanks must be filled to allow us to serve you quickly and efficiently.
Thank you for your cooperation.

Name: _____ **Date of Birth:** _____/_____/_____

Where is your problem located? ❑ Neck ❑ Upper Back ❑ Arm ❑ Lower Back ❑ Hip ❑ Leg

How long have you had this problem? _____

Briefly, please give the details of how this problem originally started: _____

_____

What is your pain level today?

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Please describe the quality of your pain: ❑aching ❑burning ❑stabbing ❑throbbing ❑tingling

Work History:

Occupation: _____

Are you currently working? ❑No ❑Yes ❑ full duty ❑ restricted duty (since _____)

❑ Retired ❑ Unemployed ❑ Student ❑ Homemaker ❑ Caregiver

Disabled through Social Security (SSDI) since _____.

Was this from a work-related injury? ❑ No ❑ Yes Is it under Workers' Compensation? ❑ No ❑ Yes

Date of injury:_____/_____/_____ How did the injury happen?_____

_____

Have you missed any work because of this problem? ❑ No ❑ Yes How much?_____

First date missed: _____ Job title when injured: _____

Usual work activities: _____

Employer at the time of injury: _____ Employer's phone: _____

Employer's address: _____

Was this from a motor vehicle accident? ❑ No ❑ Yes Date of Accident: _____/_____/_____

I authorize Long Island Spine Specialists to discuss my medical care with person (s) designated below:

Name: _____Phone:_____ Relationship to you: _____

Name: _____Phone:_____ Relationship to you: _____

(Continued on next page)

Name:_____

CURRENT MEDICATIONS- Including *Over-The-Counter/* Vitamins & Supplements		
Name	**Dose**	**Directions on Use**

ALLERGIES	
Substance	**Reaction**

Current Pharmacy: _____**Town:** _____

Do you have a Pain Management Doctor? ❑ No ❑ Yes **Doctor's Name**: _____

MEDICAL HISTORY

❑ No significant medical history. Are you pregnant/possibly pregnant? ❑ No ❑ Yes Last Menstrual Period_____

❑ **CANCER**/type _____

CARDIOVASCULAR:
- ❑ heart attack
- ❑ hypertension
- ❑ high cholesterol
- ❑ heart murmur
- ❑ mitral valve prolapse
- ❑ blood clot legs/lungs
- ❑ Raynaud's

DERMATOLOGIC:_____

HEMATOLOGIC:
- ❑ anemia
- ❑ bleeding disorder

GASTROENTEROLOGIC:
- ❑ GERD
- ❑ diverticulitis
- ❑ hernia _____
- ❑ IBS

Genitourinary:
- ❑ kidney stones
- ❑ renal failure
- ❑ UTI

HEENT:_____
- ❑ cataracts
- ❑ deafness
- ❑ deviated septum

Immunologic:_____
- ❑ lupus
- ❑ HIV
- ❑ hepatitis
- ❑ TB
- ❑ STD

Metabolic/ ENDOCRINOLOGIC:
- ❑ diabetes
- ❑ thyroid disease

Musculoskeletal:
- ❑ osteoporosis
- ❑ osteopenia
- ❑ carpal tunnel
- ❑ fibromyalgia
- ❑ fracture

Neurologic:_____
- ❑ migraines
- ❑ Alzheimer's
- ❑ TIA
- ❑ seizures
- ❑ anxiety
- ❑ depression
- ❑ PTSD

Respiratory:
- ❑ asthma
- ❑ bronchitis
- ❑ emphysema
- ❑ pneumonia
- ❑ sleep apnea
- ❑ lung disease

REPRODUCTIVE:
- ❑ endometriosis
- ❑ ovarian cysts

OTHER:
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑

(Continued on next page)

Name:_____

GENERAL SURGICAL HISTORY

❑ No significant surgical history.

Please choose all additional surgeries you have had and date of procedure.

❑ angioplasty/Stent _____
❑ AAA _____
❑ pacemaker _____
❑ CABG _____
❑ valve replacement _____
❑ removal of appendix _____
❑ removal of gallbladder _____
❑ hernia repair _____
❑ colon resection _____
❑ gastric band/bypass _____
❑ kidney, bladder_____
❑ lithotripsy_____
❑ eyes _____
❑ ears_____
❑ nose _____
❑ throat _____
❑ thyroid _____
❑ hips, knees, legs, feet _____
❑ shoulders, arms, hands_____
❑ cardiac _____
❑ Joint replacement_____
❑ fracture repair _____
❑ biopsy/excision _____
❑ brain _____
❑ lung _____
❑ C-section, tubal ligation _____
❑ hysterectomy, D&C_____
❑ prostate/ TURP _____
❑ Other: _____
❑ Other: _____

SPINE SURGERY / PAIN MANAGEMENT PROCEDURES

❑ I never had a pain management procedure. ❑ I have had: (indicate date)_____

❑ Epidural Steroid Injections _____ ❑ Medial Branch Blocks _____ ❑ Facet Blocks _____
❑ SI Joint Injections _____ ❑ Trigger Point Injections _____ ❑ Radiofrequency Ablation _____

❑ I never had spine surgery. ❑ Yes, I had spine surgery. Date: _____Please indicate type below.

❑ **CERVICAL (NECK)** ❑ **THORACIC (MID BACK)** ❑ **LUMBAR (LOW BACK)**

❑ Discectomy _____ ❑ Laminectomy _____ ❑ Fusion _____ ❑ Spinal Cord Stimulator

❑ Kyphoplasty _____ ❑ Disc Replacement_____ ❑ Other:_____

Did your condition improve after your surgery? _____

SOCIAL HISTORY

TOBACCO USE:

Have you ever used tobacco ❑ No ❑ Never ❑ Yes Cigarettes smoked daily _____ cigarettes/packs_____

How many years? _____. Age started? _____. Age quit?_____ Cigars ❑ Pipe ❑

Non-smoking chewing tobacco ❑ Smokeless ❑ Snuff ❑ Age started____ Age quit? _____

Marital status ❑Single ❑ Married ❑ Divorced ❑ Widowed Number of Children: _____

I live: ❑alone ❑ with family ❑housemate ❑aide I live in: ❑House ❑Apartment ❑Assisted living ❑ Nursing facility

Do you drink any alcoholic beverages? ❑ No ❑ Yes Type: _____ ❑ former ❑ year quit
If yes, frequency: ❑daily ❑socially ❑occasionally ❑rarely

Have you ever had a problem with illicit drug use? ❑ No ❑ Yes ❑ former
Addiction treatment? ❑ No ❑ Yes _____

(Continued on next page)

Name:

FAMILY HISTORY

NO RELEVANT FAMILY HISTORY: _____ **ADOPTED (UNKNOWN)** _____

Family Spinal History: (Please indicate which family member)

- ❑ Degenerative Disc _____
- ❑ Herniated Disc _____
- ❑ Arthritis _____
- ❑ Osteoporosis _____
- ❑ Scoliosis _____
- ❑ Spondylolisthesis _____
- ❑ Stenosis _____
- ❑ Cancer/type _____

_____

PREVIOUS DIAGNOSTIC STUDIES

Please indicate whether you have had any of the following studies and write when/where the most recent was:

	No	Yes	When /Where		No	Yes	When /Where
Regular X-ray of Spine	❑	❑	_____	Myelogram	❑	❑	_____
CT Scan of spine	❑	❑	_____	Discogram	❑	❑	_____
EMG	❑	❑	_____	MRI of spine	❑	❑	_____
Bone Scan	❑	❑	_____	Bone Density/DEXA	❑	❑	_____

REVIEW OF SYSTEMS

Please check off any problems you have had in the last two months

GENERAL
- ❑ Unexplained weight loss
- ❑ Appetite change
- ❑ Fevers or chills
- ❑ Night sweats
- ❑ Marked fatigue
- ❑ Difficulty sleeping

EYES, EARS, NOSE, THROAT
- ❑ Difficulty swallowing
- ❑ Hoarseness
- ❑ Hearing loss
- ❑ Vision change

CARDIOVASCULAR
- ❑ Chest pain
- ❑ Edema

RESPIRATORY
- ❑ Cough/productive cough
- ❑ Shortness of breath

DIGESTIVE
- ❑ Nausea or vomiting
- ❑ Abdominal pain
- ❑ Frequent diarrhea
- ❑ Frequent constipation
- ❑ Uncontrolled loss of stool
- ❑ Blood in stool

SKIN
- ❑ Frequent rashes
- ❑ Frequent itchiness

NEUROLOGICAL
- ❑ Seizures
- ❑ Blackouts/fainting
- ❑ Vertigo
- ❑ Headaches/migraines

MUSCULOSKELETAL
- ❑ Joint pains/swelling
- ❑ Muscle Aches

GENITOURINARY
- ❑ Burning on urination
- ❑ Blood in urine
- ❑ Urinary incontinence
- ❑ Frequent urination
- ❑ Urinary urgency

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HEMATOLOGIC
- ❑ Easy bruising
- ❑ Easy bleeding

METABOLIC
- ❑ Cold or Heat Intolerance
- ❑ Increased thirst

IMMUNOLOGIC
- ❑ Hay Fever
- ❑ Environmental Allergies
- ❑ Food Allergies_____
- ❑ Bee Stings, etc._____

HAND DOMINANCE
- ❑ Right-handed
- ❑ Left-handed
- ❑ Ambidextrous

CORRECTIVE LENSES
- ❑ Glasses
- ❑ Contacts

Name: _____

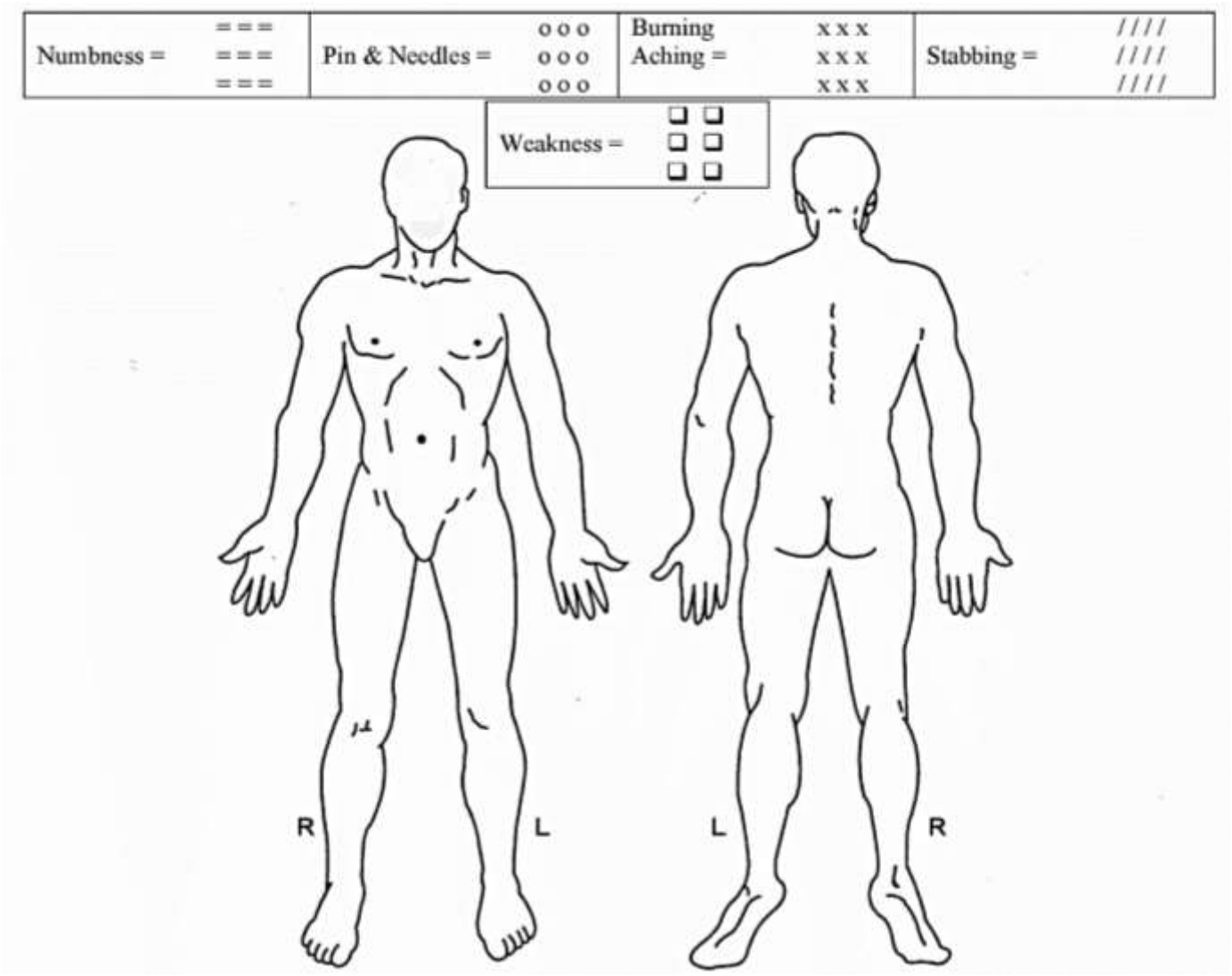
PAIN CHART

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol from the list below.

Please include all affected areas.

Numbness =	= = = = = = = = =	Pin & Needles =	o o o o o o o o o	Burning Aching =	x x x x x x x x x	Stabbing =	//// //// ////

Weakness = ❑ ❑ ❑ ❑ ❑ ❑



CURRENT PAIN PROFILE

9.) How long can you sit? ❑Unable to tolerate ❑ 15 minutes ❑ 30 minutes ❑ 45 minutes ❑ over one hour

How long can you stand? ❑Unable to tolerate ❑ 15 minutes ❑ 30 minutes ❑ 45 minutes ❑ over one hour

How long can you walk? ❑Unable to tolerate ❑ 15 minutes ❑ 30 minutes ❑ 45 minutes ❑ over one hour

(Continued on next page)

Name: _____

10.) Which of the following activities change the nature of your pain?

	Aggravates Pain	Relieves Pain	Neither
Sitting	❑	❑	❑
Standing	❑	❑	❑
Walking	❑	❑	❑
Leaning forward (brushing teeth)	❑	❑	❑
Bending forward	❑	❑	❑
Lying in your side	❑	❑	❑
Lying on your back	❑	❑	❑
Lying on your stomach	❑	❑	❑
Rising from sitting	❑	❑	❑
Changing positions	❑	❑	❑
Coughing / Sneezing	❑	❑	❑
Driving	❑	❑	❑

11.) Do you require assistance for ambulation? ❑ No ❑ Yes **If yes**, ❑cane ❑walker ❑wheelchair

THERAPIES

Please check all that apply:

	Comments	Helpful	No Help	Not Used
Pain Medications	_____	❑	❑	❑
Hot Packs	_____	❑	❑	❑
Ice applications	_____	❑	❑	❑
Ultrasound	_____	❑	❑	❑
TENS Unit/muscle stimulation	_____	❑	❑	❑
Physical therapy	_____	❑	❑	❑
Back / Neck exercises	_____	❑	❑	❑
Chiropractic treatment	_____	❑	❑	❑
Acupuncture	_____	❑	❑	❑
Traction/VAX-D	_____	❑	❑	❑
Other -	_____	❑	❑	❑

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Scoliosis

If you have scoliosis, please fill out the section below:

Name: _____

1. When was your spinal curvature first noted? _____
2. Who first noticed the curvature? _____
3. Has the curve gotten worse over time? No ☐ Yes ☐
4. What sort of treatment have you had to date? None ☐ (bracing, therapy, surgery, etc.) _____
   _____
5. If you have had scoliosis surgery, when, where, and who performed the procedure? _____
   _____

(If you have pain or weakness, please answer all questions below; if not, please skip to question 8).

6. What makes your pain worse? Sitting ☐ Standing ☐ Walking ☐ Bending Forward ☐
   Bending Backward ☐ Coughing ☐ Sneezing ☐ Nothing ☐
7. What reduces your pain? Sitting ☐ Standing ☐ Walking ☐ Medication ☐ Exercise ☐ Lying Down ☐
8. Is there weakness in your legs? ☐ No ☐ Yes
9. What diagnostic tests have you had? X-rays ☐ MRI ☐ Myelogram ☐ CT scan ☐ Discogram ☐ Bone Scan ☐
10. For Girls/Women – Have you started menses (menstrual cycles) No ☐ Yes ☐
    If Yes, Age when started? _____. Have they been regular? _____
11. **Students:** Please state your school and grade? _____
12. Are you working? ☐ No ☐ Yes - Occupation: _____
    How many days, if any, have you missed from work or school in the past year due to your back pain?
    _____
13. Is There A Family History of Scoliosis? ☐ No ☐ Yes If so, who? _____
14. How tall is your biological Mother? _____ Father? _____
    Siblings? (Age and Height) _____